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2	of the State of California ARTHUR D. TAGGART		
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10	BEFORE THE BOARD OF REGISTERED NURSING DEPARTMENT OF CONSUMER AFFAIRS STATE OF CALIFORNIA		
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13	In the Matter of the Accusation Against:  Case No. 2008-311		
14	NANCY J. CAUSEY, AKA NANCY JEAN CAUSEY A C C U S A T I O N		
15	7448 Santa Susana Way Fair Oaks, CA 95628		
16	and 5080 Chiricahua Trail Las Cruces, NM 88012		
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18	Registered Nurse License No. 544269		
19	Respondent.		
20	Complainant alleges:		
21	<u>PARTIES</u>		
22	1. Ruth Ann Terry, M.P.H., R.N. ("Complainant") brings this Accusation		
23	solely in her official capacity as the Executive Officer of the Board of Registered Nursing		
24	("Board"), Department of Consumer Affairs.		
25	2. On or about June 22, 1998, the Board issued Registered Nurse License		
26	Number 544269 to Nancy J. Causey, also known as Nancy Jean Causey ("Respondent"). The		
27	registered nurse license expired on January 31, 2008.		
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## STATUTORY PROVISIONS

	3.	Section 2750 of the Business and Professions Code ("Code") provides, in
pertinent part,	that the	Board may discipline any licensee, including a licensee holding a
temporary or a	ın inacti	ve license, for any reason provided in Article 3 (commencing with Code
section 2750)	of the N	Tursing Practice Act.

- 4. Code section 2764 provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under Code section 2811, subdivision (b), the Board may renew an expired license at any time within eight years after the expiration.
  - 5. Code section 2761 states, in pertinent part:

The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

- (a) Unprofessional conduct. . . .
- 6. Code section 2762 states, in pertinent part:

In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:

- (a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.
- (b) Use any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code, or any dangerous drug or dangerous device as defined in Section 4022, or alcoholic beverages, to an extent or in a manner dangerous or injurious to himself or herself, any other person, or the public or to the extent that such use impairs his or her ability to conduct with safety to the public the practice authorized by his or her license.
- (e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section.

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7. Code section 4060 provides, in pertinent part,

No person shall possess any controlled substance, except that furnished to a person upon the prescription of a physician, dentist, podiatrist, optometrist, veterinarian, or naturopathic doctor pursuant to Section 3640.7, or furnished pursuant to a drug order issued by a certified nurse-midwife pursuant to Section 2746.51, a nurse practitioner pursuant to Section 2836.1, a physician assistant pursuant to Section 3502.1, a naturopathic doctor pursuant to Section 3640.5, or a pharmacist pursuant to either subparagraph (D) of paragraph (4) of, or clause (iv) of subparagraph (A) of paragraph (5) of, subdivision (a) of Section 4052.

8. Section 11173, subdivision (a), of the Health and Safety Code provides:

No person shall obtain or attempt to obtain controlled substances, or procure or attempt to procure the administration of or prescription for controlled substances, (1) by fraud, deceit, misrepresentation, or subterfuge; or (2) by the concealment of a material fact.

#### COST RECOVERY

9. Code section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

## 10. **DRUG**

"Hydromorphone" or "Dilaudid", a brand of hydromorphone, is a Schedule II controlled substance as designated by Health and Safety Code section 11055(b)(1)(K), and is a dangerous drug within the meaning of Code section 4022, in that under federal law it requires a prescription.

#### FIRST CAUSE FOR DISCIPLINE

(Obtain, Possess, and Self-Administer Controlled Substance in Violation of Law)

11. Respondent's registered nurse license is subject to disciplinary action under Code section 2761, subdivision (a), on the grounds of unprofessional conduct, as defined in Code section 2762, subdivision (a), in that between in or about May 2002 to July 2002, while employed as a registered nurse at Sutter Roseville Medical Center in Roseville, California, Respondent did the following:

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- a. Respondent obtained hydromorphone, a controlled substance, by fraud, deceit, misrepresentation, or subterfuge, or the concealment of a material fact, in violation of Health and Safety Code section 11173, subdivision (a), by taking the drug from hospital supplies for her own personal use.
- b. Respondent possessed hydromorphone, a controlled substance, in violation of Code section 4060.
- c. Respondent self-administered hydromorphone, a controlled substance, without direction from a licensed physician, surgeon, dentist or podiatrist.

# SECOND CAUSE FOR DISCIPLINE

(False, Grossly Inconsistent or Unintelligible Entries in Hospital or Patient Records)

12. Respondent's registered nurse license is subject to disciplinary action under Code section 2761, subdivision (a), on the grounds of unprofessional conduct, as defined in Code section 2762, subdivision (e), in that while on duty as a registered nurse at Sutter Hospital Roseville in Roseville, California, Respondent falsified or made grossly incorrect, grossly inconsistent or unintelligible entries in hospital and patient records, as follows:

- a. On or about June 1, 2002, at 1542 hours, Respondent withdrew 2 mg of Hydromorphone from the Pyxis medication dispenser for this patient, yet failed to chart the administration or wastage of any portion of the Hydromorphone in any patient or hospital record or otherwise account for the disposition of the drug.
- b. On or about June 1, 2002, at 1857 hours, Respondent withdrew 2 mg of Hydromorphone from the Pyxis medication dispenser for this patient, yet failed to chart the administration or wastage of any portion of the Hydromorphone in any patient or hospital record or otherwise account for the disposition of the drug.
- c. On or about June 2, 2002, at 1820 hours, Respondent withdrew 2 mg of Hydromorphone from the Pyxis medication dispenser for this patient, yet failed to chart the administration or wastage of any portion of the Hydromorphone in any patient or hospital record or otherwise account for the disposition of the drug.

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- d. On or about June 3, 2002, at 1557 hours, Respondent withdrew 2 mg of Hydromorphone from the Pyxis medication dispenser for this patient, yet failed to chart the administration or wastage of any portion of the Hydromorphone in any patient or hospital record or otherwise account for the disposition of the drug.
- e. On or about June 3, 2002, at 1710 hours, Respondent withdrew 2 mg of Hydromorphone from the Pyxis medication dispenser for this patient, yet failed to chart the administration or wastage of any portion of the Hydromorphone in any patient or hospital record or otherwise account for the disposition of the drug.
- f. On or about June 3, 2002, at 1914 hours, Respondent withdrew 2 mg of Hydromorphone from the Pyxis medication dispenser for this patient, yet failed to chart the administration or wastage of any portion of the Hydromorphone in any patient or hospital record or otherwise account for the disposition of the drug.
- g. On or about June 3, 2002, at 2248 hours, Respondent withdrew 2 mg of Hydromorphone from the Pyxis medication dispenser for this patient, yet failed to chart the administration or wastage of any portion of the Hydromorphone in any patient or hospital record or otherwise account for the disposition of the drug.
- h. On or about June 3, 2002, at 2250 hours, Respondent withdrew 2 mg of Hydromorphone from the Pyxis medication dispenser for this patient, yet failed to chart the administration or wastage of any portion of the Hydromorphone in any patient or hospital record or otherwise account for the disposition of the drug.

#### Patient #2

i. On or about June 1, 2002, at 2004 hours, Respondent withdrew 2 mg of Hydromorphone from the Pyxis medication dispenser for this patient, yet failed to chart the administration or wastage of any portion of the Hydromorphone in any patient or hospital record or otherwise account for the disposition of the drug.

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- j. On or about June 2, 2002, at 1601 hours, Respondent withdrew 2 mg of Hydromorphone from the Pyxis medication dispenser for this patient, yet failed to chart the administration or wastage of any portion of the Hydromorphone in any patient or hospital record or otherwise account for the disposition of the drug.
- k. On or about June 2, 2002, at 1948 hours, Respondent withdrew 2 mg of Hydromorphone from the Pyxis medication dispenser for this patient, yet failed to chart the administration or wastage of any portion of the Hydromorphone in any patient or hospital record or otherwise account for the disposition of the drug.
- 1. On or about June 2, 2002, at 2235 hours, Respondent withdrew 2 mg of Hydromorphone from the Pyxis medication dispenser for this patient, yet failed to chart the administration or wastage of any portion of the Hydromorphone in any patient or hospital record or otherwise account for the disposition of the drug.

- m. On or about June 11, 2002, at 1532 hours, Respondent withdrew 1 mg of Hydromorphone from the Pyxis medication dispenser for this patient, yet failed to chart the administration or wastage of any portion of the Hydromorphone in any patient or hospital record or otherwise account for the disposition of the drug.
- n. On or about June 11, 2002, at 1709 hours, Respondent withdrew 1 mg of Hydromorphone from the Pyxis medication dispenser for this patient, yet failed to chart the administration or wastage of any portion of the Hydromorphone in any patient or hospital record or otherwise account for the disposition of the drug.
- o. On or about June 11, 2002, at 1711 hours, Respondent withdrew 1 mg of Hydromorphone from the Pyxis medication dispenser for this patient, yet failed to chart the administration or wastage of any portion of the Hydromorphone in any patient or hospital record or otherwise account for the disposition of the drug.

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- p. On or about June 12, 2002, at 1540 hours, 4 seconds, Respondent withdrew 1 mg of Hydromorphone from the Pyxis medication dispenser for this patient, yet failed to chart the administration or wastage of any portion of the Hydromorphone in any patient or hospital record or otherwise account for the disposition of the drug.
- q. On or about June 12, 2002, at 1540 hours, 37 seconds, Respondent withdrew 1 mg of Hydromorphone from the Pyxis medication dispenser for this patient, yet failed to chart the administration or wastage of any portion of the Hydromorphone in any patient or hospital record or otherwise account for the disposition of the drug
- r. On or about June 12, 2002, at 1749 hours, Respondent withdrew 1 mg of Hydromorphone from the Pyxis medication dispenser for this patient, yet failed to chart the administration or wastage of any portion of the Hydromorphone in any patient or hospital record or otherwise account for the disposition of the drug.
- s. On or about June 12, 2002, at 1937 hours, Respondent withdrew 1 mg of Hydromorphone from the Pyxis medication dispenser for this patient, yet failed to chart the administration or wastage of any portion of the Hydromorphone in any patient or hospital record or otherwise account for the disposition of the drug.

- t. On or about June 11, 2002, at 1857 hours, Respondent withdrew 2 mg of Hydromorphone from the Pyxis medication dispenser for this patient, yet failed to chart the administration or wastage of any portion of the Hydromorphone in any patient or hospital record or otherwise account for the disposition of the drug.
- u. On or about June 11, 2002, at 2304 hours, Respondent withdrew 2 mg of Hydromorphone from the Pyxis medication dispenser for this patient, yet failed to chart the administration or wastage of any portion of the Hydromorphone in any patient or hospital record or otherwise account for the disposition of the drug.

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- v. On or about June 12, 2002, at 1522 hours, Respondent withdrew 2 mg of Hydromorphone from the Pyxis medication dispenser for this patient, yet failed to chart the administration or wastage of any portion of the Hydromorphone in any patient or hospital record or otherwise account for the disposition of the drug.
- w. On or about June 12, 2002, at 1937 hours, Respondent withdrew 2 mg of Hydromorphone from the Pyxis medication dispenser for this patient, yet failed to chart the administration or wastage of any portion of the Hydromorphone in any patient or hospital record or otherwise account for the disposition of the drug.

- x. On or about June 15, 2002, at 1613 hours, Respondent withdrew 2 mg of Hydromorphone from the Pyxis medication dispenser for this patient, yet failed to chart the administration or wastage of any portion of the Hydromorphone in any patient or hospital record or otherwise account for the disposition of the drug.
- y. On or about June 15, 2002, at 1619 hours, Respondent withdrew 2 mg of Hydromorphone from the Pyxis medication dispenser for this patient, yet failed to chart the administration or wastage of any portion of the Hydromorphone in any patient or hospital record or otherwise account for the disposition of the drug.
- z. On or about June 15, 2002, at 2136 hours, Respondent withdrew 2 mg of Hydromorphone from the Pyxis medication dispenser for this patient, yet failed to chart the administration or wastage of any portion of the Hydromorphone in any patient or hospital record or otherwise account for the disposition of the drug.
- aa. On or about June 17, 2002, at 1532 hours, Respondent withdrew 2 mg of Hydromorphone from the Pyxis medication dispenser for this patient, yet failed to chart the administration or wastage of any portion of the Hydromorphone in any patient or hospital record or otherwise account for the disposition of the drug.

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bb. On or about June 17, 2002, at 1601 hours, Respondent withdrew 2 mg of Hydromorphone from the Pyxis medication dispenser for this patient, yet failed to chart the administration or wastage of any portion of the Hydromorphone in any patient or hospital record or otherwise account for the disposition of the drug.

cc. On or about June 17, 2002, at 1844 hours, Respondent withdrew 2 mg of Hydromorphone from the Pyxis medication dispenser for this patient, yet failed to chart the administration or wastage of any portion of the Hydromorphone in any patient or hospital record or otherwise account for the disposition of the drug.

### Patient #6

- dd. On or about June 16, 2002, at 1635 hours, Respondent withdrew 2 mg of Hydromorphone from the Pyxis medication dispenser for this patient, yet failed to chart the administration or wastage of any portion of the Hydromorphone in any patient or hospital record or otherwise account for the disposition of the drug.
- ee. On or about June 16, 2002, at 1900 hours, Respondent withdrew 2 mg of Hydromorphone from the Pyxis medication dispenser for this patient, yet failed to chart the administration or wastage of any portion of the Hydromorphone in any patient or hospital record or otherwise account for the disposition of the drug.
- ff. On or about June 16, 2002, at 2122 hours, Respondent withdrew 2 mg of Hydromorphone from the Pyxis medication dispenser for this patient, yet failed to chart the administration or wastage of any portion of the Hydromorphone in any patient or hospital record or otherwise account for the disposition of the drug.

#### Patient #7

gg. On or about June 17, 2002, at 2018 hours, Respondent withdrew 4 mg of Hydromorphone from the Pyxis medication dispenser when there was no physician's order for Hydromorphone for this patient. Respondent failed to chart the administration or wastage of any portion of the Hydromorphone in any patient or hospital record or otherwise account for the disposition of the drug.

hh. On or about June 17, 2002, at 2250 hours, Respondent withdrew 4 mg of Hydromorphone from the Pyxis medication dispenser when there was no physician's order for Hydromorphone for this patient. Respondent failed to chart the administration or wastage of any portion of the Hydromorphone in any patient or hospital record or otherwise account for the disposition of the drug.

### Patient #8

- ii. On or about June 20, 2002, at 1616 hours, Respondent withdrew 1 mg of Hydromorphone from the Pyxis medication dispenser for this patient, yet failed to chart the administration or wastage of any portion of the Hydromorphone in any patient or hospital record or otherwise account for the disposition of the drug.
- jj. On or about June 20, 2002, at 2103 hours, Respondent withdrew 1 mg of Hydromorphone from the Pyxis medication dispenser for this patient, yet failed to chart the administration or wastage of any portion of the Hydromorphone in any patient or hospital record or otherwise account for the disposition of the drug.
- kk. On or about June 21, 2002, at 1721 hours, Respondent withdrew 1 mg of Hydromorphone from the Pyxis medication dispenser for this patient, yet failed to chart the administration or wastage of any portion of the Hydromorphone in any patient or hospital record or otherwise account for the disposition of the drug.
- Il. On or about June 22, 2002, at 1942 hours, Respondent withdrew 1 mg of Hydromorphone from the Pyxis medication dispenser for this patient, yet failed to chart the administration or wastage of any portion of the Hydromorphone in any patient or hospital record or otherwise account for the disposition of the drug.

#### Patient #9

mm. On or about June 21, 2002, at 1546 hours, Respondent withdrew 1 mg of Hydromorphone from the Pyxis medication dispenser for this patient, yet failed to chart the administration or wastage of any portion of the Hydromorphone in any patient or hospital record or otherwise account for the disposition of the drug.

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nn. On or about June 21, 2002, at 2137 hours, Respondent withdrew 1 mg of Hydromorphone from the Pyxis medication dispenser for this patient, yet failed to chart the administration or wastage of any portion of the Hydromorphone in any patient or hospital record or otherwise account for the disposition of the drug.

# Patient #10

- oo. On or about July 9, 2002, at 1532 hours, Respondent withdrew 2 mg of Hydromorphone from the Pyxis medication dispenser for this patient, yet failed to chart the administration or wastage of any portion of the Hydromorphone in any patient or hospital record or otherwise account for the disposition of the drug.
- pp. On or about July 9, 2002, at 1904 hours, Respondent withdrew 2 mg of Hydromorphone from the Pyxis medication dispenser for this patient, yet failed to chart the administration or wastage of any portion of the Hydromorphone in any patient or hospital record or otherwise account for the disposition of the drug.
- qq. On or about July 9, 2002, at 2116 hours, Respondent withdrew 2 mg of Hydromorphone from the Pyxis medication dispenser for this patient, yet failed to chart the administration or wastage of any portion of the Hydromorphone in any patient or hospital record or otherwise account for the disposition of the drug.
- rr. On or about July 9, 2002, at 2259 hours, Respondent withdrew 2 mg of Hydromorphone from the Pyxis medication dispenser for this patient, yet failed to chart the administration or wastage of any portion of the Hydromorphone in any patient or hospital record or otherwise account for the disposition of the drug.
- ss. On or about July 10, 2002, at 1527 hours, Respondent withdrew 2 mg of Hydromorphone from the Pyxis medication dispenser for this patient, yet failed to chart the administration or wastage of any portion of the Hydromorphone in any patient or hospital record or otherwise account for the disposition of the drug.

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**PRAYER** WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision: Revoking or suspending registered nurse license Number 544269, issued to Nancy J. Causey, also known as Nancy Jean Causey; 2. Ordering Nancy J. Causey, also known as Nancy Jean Causey, to pay the

Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Code section 125.3; and,

Taking such other and further action as deemed necessary and proper.

DATED:

03579110-SA2008100251 Causey.Acc.wpd

baf [4/4/08]

**Executive Officer** 

Board of Registered Nursing Department of Consumer Affairs

State of California Complainant